Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHARLES W KENNEDY JR MD
STE 201
601 TEXAN TRAIL
CORPUS CHRISTI TX 78411

Respondent Name
OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative Box
Box Number 44

MFDR Tracking Number
M4-13-0613-01

MFDR Date Received
November 05, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please be advised that I am requesting your assistance in getting a remaining balance paid on a Required Medical Exam.

The adjuster, Lindsey Underhill, went through company IMED to schedule this RME. The RME was scheduled with Dr. Charles W. Kennedy Jr. in Dallas, Texas on July 13, 2012 at 9:30 am. The claimant showed for the appointment and the report was forwarded to all parties.

My office forwarded the bill and received partial payment in the amount of $325.00 on September 14, 2012. On September 19, 2012 I forwarded a Request for Reconsideration with all necessary documentation forwarded to the insurance company."

Amount in Dispute: $175.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "I have enclosed bills, EOB's and payment detail we have processed to date. We have escalated this MFDR for an additional review by the auditing company. That review is currently in process. We will supplement a response once that review is complete."

Response Submitted by: Gallagher Bassett Service, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 13, 2012	CPT Code 99456-RE	$175.00	$175.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the

procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 03, 2012

   - 59 – Processed based on multiple or concurrent procedure rules

   Explanation of benefits dated October 26, 2012

   - 59 – Processed based on multiple or concurrent procedure rules

Issues

1. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Requestor billed with CPT Code 99456- RE in the amount of $500.00 for one unit.

   Documentation provided supports a Required Medical Examination (RME) – Request for Agreement/ Request for Order addressed Extent of Injury. Per 28 Texas Administrative Code §134.204 states:

   (i) The following shall apply to Designated Doctor Examinations and

   (k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

   Therefore, CPT Code 99456-RE the total MAR is $500.00

2. The respondent issued payment in the amount of $325.00. Based upon the documentation submitted, additional reimbursement in the amount of $175.00 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $175.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/11/13 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.